VII. Criteria for Child Fatality Reviews

Child Fatality Review (CFR) Committees are required to review "eligible" deaths of all children from birth through age seventeen. O.C.G.A. 19-15-3(e)

Deaths eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

1. Sudden Infant Death Syndrome (SIDS)
2. Any unexpected or unexplained conditions
3. Unintentional injuries
4. Intentional injuries
5. Sudden death when the child is in apparent good health
6. Any manner that is suspicious or unusual
7. Medical conditions when unattended by a physician (unless the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31)
8. Serving as an inmate of a state hospital or a state, county, or penal institution

VIII. Child Fatality Review Process

- When a county medical examiner or coroner receives a report regarding the death of any child, he or she shall within **48 hours** of the death notify the chairperson of the CFR Committee of the county or circuit in which such child resided at the time of death.

- If the death of a child occurs outside the child's county of residence, it is the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner and the chairperson in the county of the child's residence.

- The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

- (1) If the death **does not meet** the criteria for review, the coroner or medical examiner shall complete and sign the form designated by the Panel stating that the death does not meet the criteria for review. He or She shall forward the form and findings, within **seven days** of the child's

death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence; or

(2) If the death **does meet** the criteria for review, the coroner or county medical examiner shall complete and sign the form designated by the Panel stating that the death meets the criteria for review. He or She shall forward the form and findings, within **seven days** of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence.

- When the chairperson of a local CFR Committee receives a report from the coroner or medical examiner regarding the death of a child, that chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

  (1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with the decision, the chairperson shall sign the form designated by the Panel (Form 1) stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the Panel within **seven days** of receipt;

  (2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with the decision, the chairperson shall follow the procedures for deaths to be reviewed;

  (3) If the report indicates the child's death meets the criteria for review, and the chairperson disagrees with the decision, the chairperson shall sign the form designated by the Panel (Form 1) stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

  (4) If the report indicates the child's death meets the criteria for review and the chairperson agrees with the decision, he or she shall follow the procedures for deaths to be reviewed.

- When a child's death meets the criteria for review, the chairperson shall convene the review committee within **30 days** after receipt of the report for a meeting to review and investigate the cause and circumstances of the death.

- The CFR Committee must prepare its report concerning the cause and circumstances of the child's death within **20 days**, excluding weekends and holidays, following the first meeting convened by the chairperson.

- Within **15 days** of its completion, the CFR committee must transmit a copy of its report to the Panel.

- The District Attorney of the county or circuit must also receive the report of the Committee with 15 days of completion when the child's death was the result of:

    a. Sudden Infant Death Syndrome(SIDS) and no autopsy was performed to confirm this diagnosis
    b. Accidental death that could have been prevented
    c. Any sexually transmitted disease
    d. Medical causes that could have been prevented
    e. Suicide of a child known to DHR or when the findings of suicide is suspicious
    f. Suspected or confirmed child abuse
    g. Trauma to the head or body
    h. Homicide

CHILD FATALITY REVIEW TEAM
TIMEFRAMES AND RESPONSIBILITIES

If child is a resident of the county, medical examiner or coroner will notify chairperson of child fatality review committee in the childís county of residence within **48 hours** of receiving report of child death (Code Section 19-15-3).

If child is not a resident of the county, the medical examiner or coroner of the county of death will notify the medical examiner or coroner and chairperson in the county of the childís residence within **48 hours** of the death. Within **7 days**, coroner/medical examiner in county of death will send coroner/medical examiner and chairperson in county of residence a copy of Form 1 along with any other available documentation regarding the death.

Medical examiner or coroner reviews the findings regarding cause of death.

Upon receipt, coroner/medical examiner in county of residence will follow outlined procedures

If cause of **death <u>meets</u> the criteria** for review pursuant Code Section 19-15-3(e), medical examiner or coroner will complete Form 1 and forward to the chair of the child fatality review committee for review within **7 days** of childís death.

If cause of **death <u>does not meet</u> the criteria** for review pursuant to Code Section 19-15-3(e), the medical examiner/coroner will complete Sections A, B, and J of Form 1 and forward to the chair of the child fatality review committee within **7 days**.

Committee meets to review report and conduct investigation into the child death within **30 days** of receiving the report.

If chair believes death meets the criteria for review, chair will call committee together.

If chair of committee agrees that death does not meet criteria for review, then chairperson signs Section J of Form 1 and forward to the Office of Child Fatality Review

Committee will complete its investigation within **20 days** after the first meeting following the receipt of the medical examiner or coronerís report.

Committee transmits a copy of its report within **15 days** of completion to the Office of Child Fatality Review.

Send a copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

IX. Committee Operating Procedures

A. Information Sharing

Child Fatality Review (CFR) Committees are not a mechanism for criticizing or second-guessing any agency's decisions; they are a confidential forum for the sharing of information essential to the improvement of a community's response to child fatalities.

A CFR Committee may request information and records regarding a deceased child as necessary to carry out the purpose and duties of the committee. Background and current information from the records of committee members and other sources may be needed to assess circumstances of the child's death. The CFR Committee may obtain from any Superior Court Judge of its County or Circuit a Subpoena to compel the production of documents, or attendance of witnesses, when the Judge find such documents or witnesses are necessary for the Committee's review process.

Information from a review can contribute significantly to the outcome of a pending investigation. Committee members should use the knowledge and expertise obtained during confidential reviews to gather additional input for pending investigations.

B. Confidentiallity

CFR Committee meetings are not subject to Georgia's Open Meetings Law. All committee members must agree to keep information regarding the child fatality review confidential. It is critical that confidentiality be enforced if each agency is to participate fully in the meeting. Committee members are not criminally or civilly liable for information made available for review by the committee. Information about the identity of the deceased child must remain confidential. The CFR report is also confidential. Members cannot disclose any confidential information acquired at the reviews, except within the mandates of their agencies' responsibilities. Disclosure of information about committee meetings or the identity of a child is punishable as a misdemeanor.

C. Maintain a Committee Membership Roster

Maintain and circulate among members a current listing of CFR Committee members, along with their addresses, telephone and fax numbers as well as e-mail addresses. The chairperson should request mandated agencies to replace committee representatives as vacancies occur. If an agency fails to fill a vacancy, the Chief Superior Court Judge of the circuit should be notified and

asked to fill the vacancy as soon as possible. The chairperson should also make sure that new committee members receive training. The Panel staff is available to provide training to members on request. The Panel should receive an updated listing of all committee members at least annually.

D. Member Designees and Meeting Attendance

Committee members may designate another representative of their agency to replace them at the meetings in the event that they are unable to attend. Members must recognize the need to attend meetings regularly to offer the expertise and knowledge which initially determined their selection.

Agencies of members who are consistently unable to attend meetings should be contacted by the committee's chairperson to request selection of another member to represent the agency on the committee. If the agency fails to respond, the chairperson should contact the chief superior court judge pursuant to O.C.G.A. 1915-3(d).

E. Child Death Information Distribution

The chairperson compiles and sends to all committee members a summary sheet for each death to be reviewed. This information is gleaned from Form 1 (coroner's) report. Prior to the CFR Committee, members should examine the sheet and search their own agency records for information pertaining to the deceased child and other family members.

F. CFR Meeting Summary Sheet

The following information is compiled and sent to each committee member. CFR Meeting Summary Sheets have been designed for this purpose. (See Attachment A and B)

1. Deceased child's name
2. Child's race, ethnicity, age, and gender
3. Child's date of birth and date of death
4. Mother's name and address (both maiden and current names are usually required for background checks and prior Child Protective Service involvement)
   If mother's name is unavailable, use father's or legal guardian's name and address
5. Circumstance of death (may be pending when the list is initially written). Circumstance of death is the specific reason the child died, (e.g., car accident, blunt force head injury, gunshot)
6. Brief description of circumstances surrounding death if available

G. Record Keeping

Agency records brought to committee meetings should leave with the member who brought them. Committees should not maintain their own records after obtaining verification of receipt by the Georgia Child Fatality Review Office. Refer all public record information requests or questions regarding CFR reports directly to the Panel.

Information should be shared verbally. In the event that written case notes are shared, they should be collected and shredded at the end of the meeting unless it becomes a part of the official record.

The Georgia Child Fatality Review Report is to be completed on all deaths reviewed. In addition, any other applicable supplemental reports should be included (i.e. police reports, autopsy reports, death certificates, coroner reports, and medical information). These reports are sent to the Panel where the data is entered and aggregated.

H. Death Certificate Information Sheets

Death Certificate Information Sheets (DCIS), which detail eligible child deaths that have occurred within your county, will be distributed to the chairperson monthly. The information is taken from death certificates filed with Vital Records. The death certificate information should be used as a **back up** resource to the coroner's initial notification. The DCIS will provide general information involved in the local child death review and investigation. The DCIS also provides pertinent information such as the county of residence, county of death and the underlying cause of death. This should eliminate the need for your committee to obtain an official death certificate.

Please be aware that each year a small number of child deaths are not filed with Vital Records. Therefore, any other means of obtaining child death information should continue to be used within the local committee (e.g. coroner, health dept, etc).

The chairperson can maintain a record of issues raised relating to committee or various agency operations

I. Training

The Georgia Child Fatality Review Panel provides quality training and consultation to each of the 159 county Child Fatality Review Committees and each committee member, in order to help communities to keep children from dying a preventable death. Child Fatality Review Trainings are required to be

given by the Georgia Child Fatality Review Panel yearly. The trainings will be located primarily in different regions throughout the state. All mandated committee members (see Committee Membership section for listing of members) or a representative from each agency is **mandated** by policy to attend the trainings. Because O.C.G.A. gives responsibility for CFR team participation to the Chief Superior Court Judge, as stated in O.C.G.A. 19-15-3 c & d, the Chief Superior Court Judge within each circuit will be given notification of the training and will be notified of all agencies that did not attend the training.

J. County CFR Annual Report

The Child Fatality Review Annual Report from each county is due by **July 15th** of each year. The report shall:

1. Specify the numbers of reports received by the review committee from the county medical examiner/coroner
2. Specify the number of child fatality review reports prepared by the committee during that year
3. Be published at least once annually, in the legal organ (newspaper) of the county or counties for which the review committee was established with the expense of such publication paid by the county
4. Prevention methods established for any causes of death

X. Conducting an Effective Review Committee Meeting

A. Beginning the Meeting

New members and ad hoc members (e.g. student interns or those individuals involved in the evaluation of the process) should sign the confidentiality agreement prior to the start of the review meeting. Each new or regular member agrees to keep meeting discussions and information confidential. (See attachment B for sample confidentiality form)

Committee members are reminded by the chairperson that:

- The review meetings are closed to the public and not subject to Georgia's Open Meeting Law
- All participants agree to keep the discussion confidential
- The committee keeps no written record of the meetings, except for CFR reports until verification of receipt by the Office of Child Fatality Review

- Members come and leave with their own records unless it becomes a part of the permanent record
- The purpose of the CFR Committee is to improve investigations, services, agency practices and to identify ways to prevent other child deaths

The chairperson addresses any logistical issues prior to conducting reviews.

B. Sharing Information

Reviews are conducted by discussing each child death individually. It can be helpful to use the CFR Report Form as a discussion guide. This will help meetings run smoothly and make report completion easier. Reviews begin with individual agency presentations. Members provide information from their agencies' records and, when appropriate, distribute it to other members. If information is distributed, it must be collected again before the end of the meeting.

The following is a suggested order for information to be shared:

1 . The medical examiner or coroner presents information on the investigation, autopsy and pending or final determination of cause and manner of death
2. The law enforcement representative presents information on the scene and other investigations
3. The Department of Family and Children Services representative reports on any information it has on the family, child, or related circumstances
4. The district attorney reports on the status of the investigation and any legal action
5. The public health representative reports any information it has on the family, child or circumstances with the health department, or other medical sources
6. The mental health representative reports on information regarding psychological or substance abuse issues related to events that caused, or contributed to, a child's death
7. Other committee members report on any information that they have and can share with the committee

C. Clarification

CFR Committee members should ask for clarification or raise questions about the information shared when unclear. Prior to moving on with a review, all committee members should feel confident that they understand all information as presented or ask for further clarification.

D. Review Discussion

The chairperson should ask the following questions, each of which should be answered thoroughly before proceeding to the next case. When all the questions have been answered to the committee's satisfaction, the review should move to the next case.

1 . Is the investigation complete, or should we recommend further investigation? If so, what more do we need to know?
2. Are there services we should provide to family members and other persons in the community as a result of this death?
3. Are other children at risk of imminent harm? If so, what action should be taken to protect them?
4. Did agencies involved with the child/family provide adequate services? If not, explain.
5. Could agencies involved with the child/family have prevented the death?
6. Should we recommend any changes to agency practices or policies based on what we know about the circumstance, cause and manner of this child death?
7. What risk factors were involved in this child death?
8. Could this death have been prevented?
9. What do we recommend should be done to prevent a similar death in the future?
10. Who should take the lead in implementing our recommendations for prevention?
11. Is our review of this case complete or do we need to discuss it at our next meeting?

E. Holdover Reviews

Cases may need to be discussed at more than one meeting. Investigative results may be incomplete at the time of the first review. Committee members may wish to obtain additional information from their agencies. A committee member with significant information may be absent. Or, a case may continue to progress and need to be updated.

F. Referrals

If a review committee identifies the need for services, referrals should be made. Referrals are usually handled by the committee member professionally associated with the program or agency that provides the appropriate service. However, any member can assist in making a referral. Committees should discuss how referrals will be made and who will be responsible for handling them.

G. Agency Conflict Resolution

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second-guess an agency's decision regarding a case. Issues with procedures or policies of a particular agency are sometimes identified; however, that agency's committee member is responsible for follow-up on concerns raised by the committee.

Committees are not peer reviews. They are designed to examine system issues, not the performance of individuals. The committee review is a professional process aimed at improving systemic response to child deaths.

Most agencies participating on committees do not have an internal mortality review process. Child Protective Services conducts reviews of child fatalities in which there has been prior contact with the agency. Some hospitals conduct internal reviews for child deaths. For most agencies, review committees provide a forum that previously did not exist for reviewing their actions, policies, and procedures.

When conflict occurs among members, the chairperson should intervene at the meeting to allow the review to progress. The chairperson can contact the members outside the meeting to discuss and help resolve conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable; reviews are to be conducted in a professional manner.

H. Media Relations

It is important that committees establish effective working relationships with the media. Media involvement is fundamental to a review committee's ability to foster awareness, educate the public regarding child deaths, and promote child death prevention strategies.

Each committee should designate one member to be the media contact. This person should contact various local media and provide information about the committee, its purpose and operation. The media contact can provide the media with statistics and/or reports relating to committee activities. Confidential case information cannot be disclosed. Because the objectives and review process are frequently misunderstood by the media, the chairperson and members need to reinforce that the committee is not a "fault-finding" panel.

XI. Maintaining an Effective Review Committee

A Child Fatality Review (CFR) committee follows three stages of development to achieve its goal of reducing the number of preventable child deaths in the community:

1. Organization
2. Operation
3. Maintenance

Once a committee has been established and its operating procedures are thoroughly understood, maintenance of the committee is essential. The following are some recommendations for maintaining a functional review committee:

A. Respect Committee Agreements

For the committee to operate effectively, it is essential that the committee agreements be recognized and followed by all committee members.

B. Participate and be Prepared for Meetings

Committee reviews require regular attendance and participation by the committee members. Members should become acquainted with the questions on the Child Fatality Review Report to facilitate their record preparation. Prior to each meeting, members should gather relevant information on each case on the agenda.

C. Keep Regular Meeting Schedules

Establishing regularly scheduled meetings provide committee members with the ability to make long-term schedule plans and allow for greater attendance. Canceling scheduled meetings diminishes a committee's ability to gather information and impede the cooperative networking of the members. A committee can only achieve its objectives by meeting routinely and regularly.

Counties and circuit-wide committees that do not have child deaths on a regular basis should meet at least quarterly for updates, training, information sharing and any other pertinent information related to the operations of the committee.

D. Provide an Educational Element at Committee Meetings

Keep members informed of committee related training, changes in laws relevant to children, and new child death or injury prevention programs. Ongoing education should be an integral part of every review committee's operation. Periodical presentations and informative handouts enhance a committee's ability to accomplish its objectives.

E. Collaborate within the Network of Review Committees

When a committee needs information on a case or identifies certain trends, be sure to contact other county CFR committees for suggestions on how they handled a problem or to obtain input on innovative committee efforts.

F. Utilizing the Child Fatality Review Panel

Occasionally, a local CFR Committee is unable to reach a consensus regarding the cause or circumstances of a child fatality, or may be unable to proceed for other reasons. The committee should not hesitate to ask the Panel to review the case in such circumstances. The Office of Child Fatality Review is in place to:

- Review local child fatality committee reports
- Provide training and technical assistance
- Identify factors and trends that put children at risk by analyzing aggregated fatality reports

G. Complete the Child Fatality Review Report in a Timely Manner

The CFR Report becomes the Panel's database on child fatalities. By completing it accurately, the Panel will develop a rich source of information on all child deaths within your county and statewide. This information will help the Panel in recommending policy, practice and programs for child safety and protection. This information will also assist your county in recognizing patterns of child deaths which can result in more informed decisions on prevention eff orts.

H. Provide Other Members with Support

Each profession brings to the review committee its perspective, professional knowledge and expertise. It is support, not criticism that will encourage change and foster improvements. Disagreement between members is sometimes unavoidable, but if handled appropriately, can help the committee function effectively. It is the responsibility of the chairperson to reinforce productive exchanges and discourage dialogue disruptive to the review process.
Each member must acknowledge and respect the professional role of each participating agency. Improvements will come through cooperative effort, not coercion.

I. Avoid Losing Sight of the Committee's Purpose and Objectives

A periodic review of the committee's stated purpose, goals, and objectives will provide direction to the team and remind members why the committee was originally formed.

J. Committee Membership is a Long-Term Commitment

A review committee is not an ad-hoc committee that collects data on child deaths for a designated period. It is a panel of professionals dedicated to establishing a better understanding of the causes of child deaths in their community. Discovering the patterns that cause or contribute to preventable child deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired by team members provides structure for achieving effective results.

K. A CFR Committee Is Both a Message to the Community and a Message from the Community

By participating on a CFR committee, local professionals who are responsible for the protection, health, and safety of their community's children communicate their pledge to better understand child deaths. Their participation represents their commitment to eliminating obstacles to integrated community responses to child deaths and to creating opportunities to prevent deaths of other children.

XII. Prevention

The ultimate purpose of child fatality reviews is to prevent future deaths. By understanding how and why children die, our communities can take action to prevent other similar deaths. A preventable death is defined by the Office of Child Fatality Review as one in which, with *retrospective analysis,* it is determined that a *reasonable intervention* (e.g., medical, educational, social, psychological, legal, or technological) could have prevented the death. Committees should make sure that every child death that could have been prevented makes a difference in the lives of other children. They should make sure that recommendations are made and acted upon.

The key to good prevention is leadership by serving as catalysts for community action. Prevention efforts can range from simply changing one agency practice or policy or setting up a stop sign at a dangerous intersection to more complex intervention like intensive home visitation programs for high risk parents.

Review committees should work with local community initiatives involved in child health, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. If available connect the committee findings to these groups to ensure results.

Examples of Prevention Strategies include:

- Public forums
- Media campaigns
- Collaboration with targeted education or intervention efforts
- Changes in agency practice
- Local resources or ordinances
- Community safety project
- School-based programs
- Consumer product safety action

Examples of prevention categories include:

- SIDS Risk Reduction
- Teen Pregnancy Prevention
- Suicide Prevention and Counseling
- Firearm Safety
- Crime's Victim's Assistance
- Poison Control
- Gang Prevention and Intervention
- Substance Abuse Education
- Drowning Prevention
- Bicycle Safety
- Prenatal Medical Care
- Parenting Skills
- Child Abuse and Neglect Prevention
- Consumer Product Safety
- Domestic Violence
- Seat Belt Safety
- Infant and Child Day Care programs

XIII. Resources

Committee members should contact the numerous agencies and organizations that have established prevention programs for assistance and information. This list includes only a few of the groups that can assist committees.

A. National Organizations

National SAFE KIDS -www.safekids.org
US Health and Human Services Department- www.hhs.gov
US Department of Justice - Juvenile Crime Prevention Department - www.usdoj.gov
SIDS National Clearinghouse - McLean, Virginia-www.nichd.nih.gov/SIDS
National Safety Council-www.nsc.org

National Committee to Prevent Child Abuse, 1-800-CHILDREN - www.childabuse.org
National Center on Child Abuse and Neglect - www.djjdp.ncjrs.org
Annie B. Casey Foundation - www.aecf.org
Centers for Disease Control and Prevention -Atlanta, Georgia - www.cdc.org
National Institute for Mental Health - www.nimh.nih.gov
For Love of Children (FLOC) - www.floc.org
Consumer Product Safety Commission - www.cpsc.gov

B. State Organizations

Georgia Children's Trust Fund Commission - www.cfchildren.org
Georgia Coalitions of SAFE KIDS - www.safekids.org
Georgia Prevention Network - www.gpnetwork.org
The Georgia Childhood Lead Poisoning Project - www.cdc.org
Prevent Child Abuse Georgia - www.preventchildabusega.org
Georgia Region, National Highway Traffic Safety Administration - www.nhtsa.dot.gov
Department of Human Resources, Division of Public Health - www.ph.dhr.state.ga.us

C. Professional Associations

Professional associations are created to provide assistance, training, and information for their members. As a resource, they can offer teams updates on changes to laws that affect various professions, and information regarding training and programs that relate to committee activities.

Georgia Hospital Association – www.gha.org/ghhs
American Bar Association's Center on Children and the Law – www.abanet.org
American Professional Society on the Abuse of Children – www.apsac.org
Child Welfare League of Atlanta – www.cwla.org